Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTHEAST HEALTH SERVICES
PO BOX 170336
DALLAS TEXAS 75217

Respondent Name
DALLAS ISD

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-07-3966-01

MFDR Date Received
March 2, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the table of disputed services: "Code 97039 was denied as 'invalid coding.' Please see the attached documentation marked Exhibit #1 for clarification of this service. Code 97140-59 was denied as 'not preauthorized,' please note that per the TWCC guidelines, preauthorization is not required until after the third visit. Code 99080-73 was denied as 'no change in work status,' please see the attached documentation marked Exhibit #2 for clarification of this service. Furthermore, this was the first TWCC-73 performed for this patient's injury. This report was ital to inform all parties of the patient's off work status and was necessary."

Amount in Dispute: $170.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "An allowance of $6.15 with interest is recommended for code 97039 for dates of service 04/25/06, 05/11/06 and 05/22/06. No allowance is recommended for any of the codes billed on April 26, 2006. Procedure code 97140 is a timed code and the medical records do not specify the amount of time for the treatment. Procedure codes 97032 and 97016 are not documented in the medical records. The provider billed code 99080-73 on April 24, 2006 and April 26, 2006. Since we previously recommended an allowance for April 24, 2006 and there was not a change in work status, no allowance is due for April 26, 2006. A copy of the explanation of benefits for April 24 is enclosed. For date of service, May 11, 2006 an allowance of $28.25 with interest is recommended for code 99211."

Response Submitted by: Argus Services Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 25, 2006, April 26, 2006, May 11, 2006 and May 22, 2006	Physical therapy services, office visit, DWC-73	$170.98	$75.35

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute resolution for which the dispute resolution request was filed on or after January 15, 2007.
2. 28 Texas Administrative Code §134.202 sets out the fee guideline for professional medical services provided on or after September 1, 2002.
3. 28 Texas Administrative Code §134.600, sets out the preauthorization guidelines.
4. Division rule at 28 TAC §134.1, effective May 16, 2002, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 16, 2006
   - W1A – Workers Compensation State Fee Schedule Adjustment. * Reimbursement per Rule 134.202.
   - W1R – Workers Compensation State Fee Schedule Adjustment. * Incorrect CPT/HCPC code for this service/procedure
   - 62A – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization
   - D196 – Claim/service lacks physician/operative or other supporting documentation. * No change in work status. DWC form-73 not required.

   Explanation of benefits dated June 12, 2006
   - 97H – Payment is included in the allowance for another service/procedure.
   - W1A – Workers Compensation State Fee Schedule Adjustment. * Reimbursement per Rule 134.202
   - W1B – Workers Compensation State Fee Schedule Adjustment. *Incorrect CPT/HCPC code for this service/procedure.

   Explanation of benefits dated August 15, 2006
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration
   - W1A – Workers Compensation State Fee Schedule Adjustment. * Reimbursement per Rule 134.202.
   - W1R – Workers Compensation State Fee Schedule Adjustment. * Incorrect CPT/HCPC code for this service/procedure.
   - 62A – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization
   - W4M – No additional reimbursement allowed after review of appeal/reconsideration. * No change in work status. DWC form 73 is not required.
   - 97H – Payment is included in the allowance for another service/procedure

Issues

1. Did the requestor obtain preauthorization for the disputed charges?
2. Did the requestor bill for bundled/global codes?
3. Did the requestor submit documentation to support fair and reasonable reimbursement for the unvalued codes?
4. Did the requestor submit documentation to support the billing of procedure codes 97140-59, 97032, 97016, 99080-73 rendered on April 26, 2006?
5. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600, amended to be effective March 14, 2004 "(p)Non-emergency health care requiring preauthorization includes: (5)physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (C)except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (i)the date of injury, or..."
   - The injured employee's date of injury is April 24, 2006.
   - The requestor seeks resolution for therapy services rendered on April 25, April 26, May 11 and May 22, 2006.
   - Treatment within the first two weeks post injury would cover date of service April 25 and April 26, 2006. May 11 and 22, 2006 are over the first two weeks immediately following the date of injury. Therefore preauthorization is required for physical and occupation therapy services.
   - Preauthorization was not obtained for dates of service May 11 and 22, 2006. Reimbursement cannot be recommended for CPT code 97039.
   - Physical and occupation therapy services rendered on April 24, 2006 and April 26, 2006 are not subject

to the preauthorization requirement of 28 Texas Administrative Code §134.600.

- Preauthorization was not required for treatment rendered within the first two weeks for dates of service April 25, April 26, 2006. These dates of service will be reviewed according to the applicable rules.
- Preauthorization is not required for office visits. The office visit charge (99211) will be reviewed according to the applicable fee guidelines.

2. Per 28 Texas Administrative Code §134.202 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." CCI edits were run to determine if edit conflicts exist for dates of service April 25, 2006, April 26, 2006, and May 11, 2006. Review of the CCI edits finds:
   - No CCI edit conflicts were identified
3. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." Review of the submitted documentation finds that:
   - CPT code 97039 is defined as "Unlisted modality (specify type and time if constant attendance)"
   - Review of the Medicare Fee Schedule, does not contain an assigned value, therefore reimbursement is subject to Rule 134.1.

   Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (6) for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

   Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   Former 28 Texas Administrative Code §133.307(c)(2)(G), "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable; and." Review of the submitted documentation finds that." Review of the submitted documentation finds that:

   - The requestor billed CPT code 97039 on April 25, 2006.
   - The CPT code 97039 does not have a Medicare assigned value.
   - Division rule at 28 TAC §134.1, effective May 16, 2002 requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for CPT code 97039.
   - Documentation of the comparison of charges to other carriers was not presented for review.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor is therefore not entitled to reimbursement for CPT code 97039 rendered on April 25, 2006.
4. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for

determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%... (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule....” Review of the submitted documentation finds that:

- Review of the SOAP note dated April 26, 2006, does not document procedure codes 97032 and 97016 reimbursement cannot be recommended for CPT codes 97032 and 97016.
- The requestor billed and documented procedure code 97140-59 x 1 unit rendered on April 26, 2006. The requestor is therefore entitled to reimbursement in the amount of $ 26.91 x 125% = MAR $33.64. The requestor seeks reimbursement in the amount of $32.10, this amount is recommended.
- The requestor submitted a copy of the DWC073 dated April 26, 2006. The insurance carrier indicates that there was not a change in work status, therefore no allowance is due. The requestor indicates that this was the first DWC073 performed. The requestor is therefore entitled to reimbursement in the amount of $15.00, per 28 TAC of §129.5.
- The requestor billed CPT code 99211 on May 11, 2006, denied by the insurance carrier as global. CCI edits were run to determine edit conflicts. No edit conflicts were identified. Review of the office note meets the documentation criteria for billing CPT code 99211. Reimbursement is therefore recommended in the amount of $22.60 x 125% = MAR $28.25. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $75.35.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $75.35 plus applicable accrued interest per 28 Texas Administrative Code §134.803 for dates of service prior to 5/2/06, due within 30 days of receipt of this Order.

Authorized Signature

		March 19, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.